Corey James
Topsham
LD 555

Testimony of Corey James
In support of LD 555 (SP 217)
Joint Standing Committee on Health and Human Services
January 6, 2026

Senator Ingwersen, Representative Meyer, and members of the Health and Human Services Committee:

My name is Corey James, and I'm submitting testimony in support of LD 555, sponsored by Senator Timberlake.

I'm testifying as a former kinship foster parent. Two years ago, a child connected to my family died while in Maine's custody. At the time, I was caring for her close relative, a young child grieving that loss. That experience is a big part of why I care so intensely about the children and families in this system.

Before I begin, I want to acknowledge something briefly. I've criticized this committee publicly in the past, and at times I did it in a way that wasn't fair or constructive. I regret that. I'm submitting this testimony in good faith, and I'm asking that LD 555 be judged on its merits.

Maine's child welfare outcomes have been unacceptable for far too long. Too many children have been harmed, and too many have died, in cases where warning signs were missed or decisions went wrong. People can debate individual cases, but the long-term pattern is clear.

DHHS publishes a child fatality dashboard. Even with its caveats, the trend is staggering. The total for 2019 to 2024 is 155, versus 68 for 2013 to 2018. That's more than double. In 2024, the dashboard shows 31 deaths. That's the third highest year on record, and higher than the year before. For 2025, the number is still incomplete.[1]

We've also added funding and resources over time, but we're still here. Resources matter, but money alone hasn't been enough to prevent repeated failures and tragedies. That points to deeper issues like structure, leadership, decision-making, transparency, and consequences.

Right now, child welfare sits inside DHHS, a large agency with many priorities competing for attention, staffing, and leadership. That structure has repeatedly shown it can absorb audits, scandals, tragedies, and 'reforms' without producing changes the public can clearly see, track, and evaluate over time.

This is not about demonizing DHHS staff or blaming frontline workers. A lot of people inside the system are doing difficult work under intense pressure. But good people can still end up with terrible outcomes when the structure works against them, responsibilities are dispersed, and decision pathways are hard for outsiders to understand.

And I want to say this plainly: Maine has been talking about reform for years. We've heard plans, seen reorganizations, and watched proposals come and go. We can't keep cycling through "next steps" while outcomes keep getting worse. At some point, we have to make a structural change that matches the scale of the problem.

LD 555 would create a cabinet-level Department of Child and Family Services, led by a Commissioner appointed by the Governor and confirmed by the Legislature.

The bill transfers to the new department the child and family services responsibilities and authority currently held by DHHS. It also includes transition provisions for the transfer of funds, contracts, records, property, and staff so the change can actually be implemented. Finally, it requires regular reporting to this committee on the unmet needs of children in Maine.

I'm not claiming a structural change alone will fix every problem. It won't. But it is a necessary step if Maine wants child safety treated as a core mission with clear

direction and clear responsibility.

I also want to note LD 555 has bipartisan support. I appreciate that, and I hope it's evaluated as a child safety bill, not a party bill.

Separation matters because it changes what child protection is inside state government. It makes child protection its own department-level responsibility rather than one program area among many within DHHS.

In practical terms, separation can do three things. First, it puts child protection at the center of the mission and daily leadership attention. Second, it clarifies lines of responsibility for high-risk decisions. When critical decisions are made, it should be easier to identify who's responsible for the policies, approvals, and decision pathways involved. That won't guarantee perfect judgment, but it does make it harder for failure to disappear into "the system." Third, it gives the Legislature and the public a clearer place to focus oversight and measurement over time. Even when reporting exists today, the size and complexity of DHHS can make it hard to see what's changed and whether outcomes are improving. Separation can reduce that diffusion.

I also want to say this plainly. I'm not blaming Governor John Baldacci for the 2004 consolidation. I understand that decision came in the aftermath of the horrific death of Logan Marr and was made with the intent to improve child protection. But it's fair to re-evaluate the structure now in light of what we've learned since and what Maine has continued to experience.

I understand concerns about disruption and cost. Reorganization can go badly if it's done carelessly. Transition details matter: staffing continuity, leadership quality, clarity for families and providers, and the practical logistics of moving responsibilities without losing operational capacity.

But the status quo has costs too, and they aren't theoretical. They're paid in children harmed, families shattered, worker burnout, and public trust that keeps eroding.

If members have concerns about implementation, that's exactly what the work session is for. The question shouldn't be "perfect bill or nothing." It should be "take the necessary step, then strengthen the details."

For these reasons, I respectfully ask the committee to vote LD 555 Ought to Pass. If you've got concerns about details, strengthen the bill in work session. But a bill this important shouldn't be allowed to die quietly while children keep dying.

Finally, I want to be candid: separation is necessary, but it isn't sufficient. Even if LD 555 passes and is implemented well, Maine will still need stronger independent oversight, transparency, and accountability legislation.

Two examples of the kinds of reforms I believe Maine will still need are a truly independent watchdog with real authority, independent funding, full data access, and regular public reporting, so oversight doesn't depend on the department it's overseeing, and lawful access to more complete, unredacted information for oversight purposes, with strict privacy safeguards. Oversight can be strengthened without compromising confidentiality or dignity, but it will require careful statutory changes.

LD 555 is a necessary structural step. If Maine is serious about protecting children at the scale of this crisis, additional reforms will still be needed, ideally with support from a Governor.

Thank you for considering my testimony.

Corey James

[1] Note: Maine DHHS states its Child Fatality Reporting Dashboard is not a comprehensive list of all child deaths in Maine and reflects deaths meeting DHHS criteria tied to Office of Child and Family Services involvement or history (see DHHS dashboard methodology/notes).